		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 North County Farm Road (Number) Wheaton (City) 60187 (Zip Code)

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 665-2446

IDPA ID Number: 36-6006551-002

Date of Initial License for Current Owners: Prior to 1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics, Sr. Consultant **Telephone Number:** (847) 259-7373, Ext. 111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Dec. 1, 2003 to Nov. 30, 2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3/24/2005 (Date)
(Type or Print Name) Beth Welch
(Title) Administrator

Paid Preparer

(Signed) 3/24/2005 (Date)
(Print Name and Title) Patrick Szajkovics, Senior Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 3315 W.Algonquin Rd.S.110, Rolling Meadows,IL 60008
(Telephone) (847) 259-7373 Fax # (847) 259-9869

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	508	Skilled (SNF)	508	185,928	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	508	TOTALS	508	185,928	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	98,552	18,127	12,324	129,003	8
9	SNF/PED					9
10	ICF	1,464	0	0	1,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	100,016	18,127	12,324	130,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.17%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Empl. Meals, Empl. Pharmacy & Therapy, County Laundry & Pharmacy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started Pre - 1935

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 10,612

Medicare Intermediary Mutual of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2004 Fiscal Year: 11/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	1,547,871	149,838	4,661	1,702,370		1,702,370	(441,984)	1,260,386			1
2	Food Purchase		1,097,893		1,097,893		1,097,893	(285,044)	812,849			2
3	Housekeeping	1,454,352	231,856	38,625	1,724,833		1,724,833	(103,232)	1,621,601			3
4	Laundry	244,223	57,659	5,374	307,256	0	307,256	(10,473)	296,783			4
5	Heat and Other Utilities			1,487,275	1,487,275		1,487,275	0	1,487,275			5
6	Maintenance			699,176	699,176		699,176	(120,087)	579,089			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	3,246,446	1,537,246	2,235,111	7,018,803	0	7,018,803	(960,820)	6,057,983			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	10,850,026	554,903	1,085,262	12,490,191	(202,006)	12,288,185	(475,523)	11,812,662			10
10a	Therapy	551,708	26,494	4,265	582,467	(3,505)	578,962	1,112,304	1,691,266			10a
11	Activities	429,664	24,445	728	454,837		454,837	0	454,837			11
12	Social Services	375,390	3,458	2,661	381,509		381,509	0	381,509			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	12,206,788	609,300	1,092,916	13,909,004	(205,511)	13,703,493	636,781	14,340,274			16
	C. General Administration											
17	Administrative	119,667		576,373	696,040		696,040	0	696,040			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			114,625	114,625		114,625	0	114,625			19
20	Dues, Fees, Subscriptions & Promotions			52,488	52,488		52,488	(41,315)	11,173			20
21	Clerical & General Office Expenses	1,060,538	76,609	210,743	1,347,890		1,347,890	(8,085)	1,339,805			21
22	Employee Benefits & Payroll Taxes			4,691,080	4,691,080		4,691,080	365,417	5,056,497			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			38,674	38,674		38,674	0	38,674			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			334,753	334,753		334,753	0	334,753			26
27	Other (specify):*				0		0	0	0			27
28	**TOTAL General Administration**	1,180,205	76,609	6,018,736	7,275,550	0	7,275,550	316,017	7,591,567			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	16,633,439	2,223,155	9,346,763	28,203,357	(205,511)	27,997,846	(8,022)	27,989,824			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Du Page Convalescent Center #0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,355,354	1,355,354		1,355,354	163	1,355,517			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,355,354	1,355,354	0	1,355,354	163	1,355,517			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers	387,801	1,789,416	31,305	2,208,522	205,511	2,414,033	(171,284)	2,242,749			39
40	Barber and Beauty Shops	73,256			73,256		73,256	0	73,256			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee				0		0	278,892	278,892			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	461,057	1,789,416	31,305	2,281,778	205,511	2,487,289	107,608	2,594,897			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,094,496	4,012,571	10,733,422	31,840,489	0	31,840,489	99,749	31,940,238			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(168,558)	39		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(120,087)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,473)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,676)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (305,794)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (305,794)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		202,006	10	44
45	Other-Attach Schedule Exc Thrpy	X		3,505	10a	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 205,511		47

STATE OF ILLINOIS

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2003

Ending: Nov. 30, 2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cafeteria Income - Other Dietary Costs	$ (96,981)	1	1
2	Cafeteria Income - Food	(62,545)	2	2
3	421 Cafeteria Income - Other Dietary Costs	(345,003)	1	3
4	421 Cafeteria Income - Food	(222,499)	2	4
5	Employee Reimbursements - Other Ancillary	(2,726)	39	5
6	Other Misc Revenues	(1,409)	21	6
7	Overpayments and Refunds expense	(41,315)	20	7
8	West Campus Cleaning Revenue	(103,232)	3	8
9	Provider Participation Fee	278,892	42	9
10	Indirect IMRF cost adjustment	369,180	22	10
11	Indirect FICA cost adjustment	(3,763)	22	11
12	Loss on Disposal of Moveable equipment	163	30	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(231,238)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center **#** 0008201 **Report Period Beginning:** Dec. 1, 2003 **Ending:** Nov. 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(441,984)	0	0	0	0	0	0	0	0	0	0	(441,984)	1
2	Food Purchase	(285,044)	0	0	0	0	0	0	0	0	0	0	(285,044)	2
3	Housekeeping	(103,232)	0	0	0	0	0	0	0	0	0	0	(103,232)	3
4	Laundry	(10,473)	0	0	0	0	0	0	0	0	0	0	(10,473)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(120,087)	0	0	0	0	0	0	0	0	0	0	(120,087)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(960,820)	0	0	0	0	0	0	0	0	0	0	(960,820)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(475,523)	0	0	0	0	0	0	0	0	0	(475,523)	10
10a	Therapy	0	1,112,304	0	0	0	0	0	0	0	0	0	1,112,304	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	636,781	0	0	0	0	0	0	0	0	0	636,781	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(41,315)	0	0	0	0	0	0	0	0	0	0	(41,315)	20
21	Clerical & General Office Expenses	(8,085)	0	0	0	0	0	0	0	0	0	0	(8,085)	21
22	Employee Benefits & Payroll Taxes	365,417	0	0	0	0	0	0	0	0	0	0	365,417	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	316,017	0	0	0	0	0	0	0	0	0	0	316,017	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(644,803)	636,781	0	0	0	0	0	0	0	0	0	(8,022)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2003 **Ending:** Nov. 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	163	0	0	0	0	0	0	0	0	0	0	163	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	163	0	0	0	0	0	0	0	0	0	0	163	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(171,284)	0	0	0	0	0	0	0	0	0	0	(171,284)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,892	0	0	0	0	0	0	0	0	0	0	278,892	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	107,608	0	0	0	0	0	0	0	0	0	0	107,608	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(537,032)	636,781	0	0	0	0	0	0	0	0	0	99,749	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing	$ 475,523	Marianjoy Rehablink Corp - Joint Venture	50.00%	$	$ (475,523)	1
2	V	10a	Physical Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	525,184	525,184	2
3	V	10a	Speech Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	438,394	438,394	3
4	V	10a	Occup Therapy		Marianjoy Rehablink Corp - Joint Venture	50.00%	148,726	148,726	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 475,523			$ 1,112,304	$ * 636,781	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: ov. 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Du Page County Government
Street Address: 421 N. County Farm Road (Finance Dept)
City / State / Zip Code: Wheaton, Illinois 60187
Phone Number: (630) 407-6121 (Lynn Wood)
Fax Number: (630) 407-6102

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F. & Social Security	Direct Cost	20,484,613		$ 20,484,613	$ 0	2,629,419	$ 2,629,419	1
2	19	Legal Services	Direct Cost	0		0	0	0		2
3	19	Finance & Auditor	# of A/P Claims	692,068	162	692,068	248,182	66,100	66,100	3
4	19	County Audit	% of Time Spent	248,530	11	248,530	0	9,941	9,941	4
5	19	General Acctg & Budget	% of All Depts	1,007,320	49	1,007,320	469,488	20,558	20,558	5
6	21	Mail Delivery	Wtd Avg # of Del	300,000	44	300,000	162,343	6,569	6,569	6
7	22	Workers Comp Claims	Direct Cost	644,876	175	644,876	0	93,044	93,044	7
8	22	Worker Comp Premiums	# of Claims & FTEs	103,697	175	103,697	0	18,594	18,594	8
9	26	Property Insurance	Building Value %	292,811		292,811	0	24,684	24,684	9
10	26	Prof Liability Insurance	Direct Cost	186,000		186,000	0	186,000	186,000	10
11	26	Gen Liab & Surety Bnd	Direct Cost	778,886		778,886	0	89,291	89,291	11
12	22	Unemployment Comp Ins	Direct Cost	293,126		293,126	0	33,097	33,097	12
13	12	Service retention Fee	# of Ins Claims	108,142	18	108,142	0	34,779	34,779	13
14	5	Utilities, Space & HVAC	Square Footage	9,557,236	46	9,557,236	2,772,262	989,165	989,165	14
15	17	Security	Square Footage	921,988	57	921,988	576,802	188,074	188,074	15
16	6	Building Maintenance	Direct Cost	2,428,040		2,428,040	739,522	685,165	685,165	16
17	21	Telecommunications	Direct Cost	0		0	0	0		17
18	6	Rental of Equipment	Direct Cost	11,624		11,624	0	726	726	18
19	6	Repair & Maint of Equip	Direct Cost	69,707		69,707	0	7,435	7,435	19
20	17	Personnel Costs	% of Ads & FTEs	1,709,146	45	1,709,146	914,652	322,831	322,831	20
21	17	Purchasing Costs	# of Purchase Orders	1,141,369	92	1,141,369	334,460	48,509	48,509	21
22	17	County Board	Comm Assignmnts	874,005	55	874,005	874,005	16,959	16,959	22
23										23
24										24
25	TOTALS					$ 41,853,184	$ 7,091,716		$ 5,470,940	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$ 0	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Reinf Concrt Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Bldgs	400,000	Various	$ 784,360	1
2					2
3	TOTALS	400,000		$ 784,360	3

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1947	$ 70,858	$ 0	30	$ 0	$	$ 70,858	4
5				1983	1,172,064	34,473	34	34,473		744,032	5
6	104			1978	4,456,548	148,552	30	148,552		3,948,997	6
7	16			1979	1,750,524	58,351	30	58,351		1,468,496	7
8	100			1993	6,516,821	238,419	Various	238,419		2,862,963	8
	Improvement Type**										
9	Mech room renovation & heat exchangers			1976	44,372	0	20	0		44,372	9
10	Alarm equip doors & other, Project 181			1977	8,545	0	20	0		8,545	10
11	Cyclone dust collector			1978	12,188	0	20	0		12,188	11
12	Flagpole			1979	844	0	20	0		844	12
13	Kitchen floor / Ground north remodel			1981	212,304	0	20	0		212,304	13
14	South Bldg renovation - Phase III (Per 1989 Adj)			1983	3,871,516	0	20	0		3,871,516	14
15	South Bldg renovation - Phase III Architect fees			1983	262,953	0	20	0		262,953	15
16	Laundry, 3-Center & Nurse station remodel			1985	261,742	9,948	15/20	9,948		251,797	16
17	Tubs & Parking lot projects			1989	199,883	9,994	20	9,994		149,082	17
18	Oxygen Manifold - North Bldg			1990	5,423	271	20	271		3,774	18
19	Ground North & Hydrotherapy remodel			1991	331,512	18,438	15/20/25	18,438		238,160	19
20	Window replacement, 3-Center & Nurse station remodel			1992	604,207	32,536	10/15/20/25	32,536		416,420	20
21	Laundry water heater & softners, asphalt rep & landscape			1993	588,826	30,801	10/12/15/20	30,801		380,454	21
22	ADA & Elevator upgrades, Nurse station remodel & misc			1994	105,577	4,940	5/10/15/20	4,940		70,812	22
23	Sewer Ejector pumps & Carpet replacement			1995	31,457	2,776	5/10	2,776		30,763	23
24	Carpet replace in Recreation & Volunteer areas & misc			1996	7,963	0	5	0		7,963	24
25	Chilled water bridges, Liquid oxygen, Lights refit & Elevator			1997	320,587	18,808	5/10/20	18,808		139,985	25
26	Elevator Pit ladders & automatic entrance doors			1998	10,922	950	10/20	950		5,953	26
27	Lobby remodel, Carpet, Elevator safety system & HVAC			1999	701,043	76,793	5/10/20	76,793		384,658	27
28	Tubs, Reception, Laundry, Kitchen Elev, HVAC & access eqp			2000	848,131	89,018	5/10/15/20	89,018		372,864	28
29	Tub room remodel, Life safety system, Elev & Liq Oxygen eqp			2001	473,208	47,321	10	47,321		143,121	29
30	Carpeting			2002	8,582	1,716	5	1,716		4,225	30
31	Roof rehab, Card readers & Kitchen renovation			2002	219,254	21,925	10	21,925		47,611	31
32	Fire Alarm Dampers, Fire System & Constructn Admin			2002	1,515,449	151,545	10	151,545		303,126	32
33	Director Signage			2002	65,448	3,272	20	3,272		6,817	33
34	HVAC Modifications			2002	102,341	6,822	15	6,822		13,645	34
35	Curtain Wall Installation			2003	13,140	876	15	876		1,241	35
36	Carpet Installation			2003	1,148	230	5	230		421	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fencing - Wrought Iron	2003	$ 21,810	$ 872	25	$ 872	$	$ 1,599	37
38	Curtain Wall Project	2003	338,936	33,894	10	33,894		36,718	38
39	Alarm System Prof Fees	2003	1,000	200	5	200		217	39
40	Fire Alarm System Replacement	2004	165,176	9,635	10	9,635		9,635	40
41	Hi-Res LW Light Camera	2004	2,768	92	5	92		92	41
42	Rekey Main Entrance & Door Contact Installation	2004	1,733	231	5	231		231	42
43	Pharmacy Storage Remodeling	2004	2,050	137	10	137		137	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 25,328,853	$ 1,053,836		$ 1,053,836	$ 0	$ 16,529,589	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,099,384	$ 283,826	$ 283,826	$ 0	3/4/10	$ 2,088,190	71
72	Current Year Purchases	81,020	6,433	6,433	0	3/4/10	6,433	72
73	Fully Depreciated Assets	1,391,986			0		1,391,986	73
74	Deletions	(39,349)		162	162	3/10	(39,349)	74
75	TOTALS	$ 4,533,041	$ 290,259	$ 290,421	$ 162		$ 3,447,260	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint/02 Van	Various/97 White Ford Van	Various/02	$ 182,531	$ 1,169	$ 1,169	$ 0	3/4/10	$ 180,485	76
77	Grounds Maintenance	John Deere Tractor	1999	12,685	1,269	1,269	0	10	7,294	77
78	Maint & Transport	Ford A-10 Van	2000	38,971	5,683	5,683	0	4	38,971	78
79	Maint & Transport	Window Van - 2001	2001	31,396	3,139	3,139	0	10	9,419	79
80	TOTALS			$ 265,583	$ 11,260	$ 11,260	$ 0		$ 236,169	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 30,911,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,355,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,355,517	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 162	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 20,213,018	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Miscellaneous	$ 1,533,439	92
93			93
94			94
95		$ 1,533,439	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	4191	hrs	140,064				4,191	140,064	4
5	Physician Care	Ln 10, Col 8		visits		4,550	27,500		4,550	27,500	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	68156	# of prescrpts	387,801			1,545,419	68,156	1,933,220	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program	Ln 39, Col 8			134,858			70,653		205,511	12
13	Other (specify):										13
14	TOTAL				$ 662,723	4,550	$ 27,500	$ 1,616,072	76,897	$ 2,306,295	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,470,867	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	5,361,652		3
4	Supply Inventory (priced at Cost)	373,076		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,205,595	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	25,328,853		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,481,309		16
17	Accumulated Depreciation (book methods)	(20,213,018)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	1,533,439		22
23	Other(specify): Leased Equipmnt	317,315		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,232,258	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 22,437,853	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,123,470	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,228,166		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued Liabilities	498,860		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,850,496	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Compensation	632,109		43
44	Lease purchase	167,297		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 799,406	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,649,902	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,787,951	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 22,437,853	$ 0	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 200

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 20,195,623	1
2	Restatements (describe):		2
3	Rounding variance	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 20,195,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,249,194)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,249,194)	17
	B. Transfers (Itemize):		
18	Contributed Capital	2,841,521	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,841,521	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 18,787,951	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 26,934,580	1
2	Discounts and Allowances for all Levels	(7,521,597)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,412,983	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,144,833	6
7	Oxygen	82,818	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,227,651	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,525,000	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	727,028	14
15	Telephone, Television and Radio	120,087	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,378,470	17
18	Sale of Supplies to Non-Patients	1,409	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,726	21
22	Laundry	10,473	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,765,193	23
	D. Non-Operating Revenue		
24	Contributions	26,834	24
25	Interest and Other Investment Income***	55,402	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,236	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	West Campus Cleaning Revenue	103,232	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 103,232	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 27,591,295	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,018,803	31
32	Health Care	13,909,004	32
33	General Administration	7,275,550	33
	B. Capital Expense		
34	Ownership	1,355,354	34
	C. Ancillary Expense		
35	Special Cost Centers	2,281,778	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 31,840,489	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,249,194)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,249,194)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,868	2,089	$ 102,254	$ 48.95	1
2	Assistant Director of Nursing	3,505	4,177	149,877	35.88	2
3	Registered Nurses	123,536	140,731	3,863,665	27.45	3
4	Licensed Practical Nurses	37,575	42,543	943,533	22.18	4
5	Nurse Aides & Orderlies	361,827	409,904	5,561,268	13.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	17,294	19,585	527,865	26.95	7
8	Rehab/Therapy Aides	20,998	24,191	338,466	13.99	8
9	Activity Director	1,889	2,094	53,122	25.37	9
10	Activity Assistants	22,466	25,618	376,542	14.70	10
11	Social Service Workers	16,291	18,886	375,391	19.88	11
12	Dietician	7,508	8,547	159,424	18.65	12
13	Food Service Supervisor	3,947	4,358	118,901	27.28	13
14	Head Cook	1,927	2,206	36,165	16.39	14
15	Cook Helpers/Assistants	57,886	64,251	718,788	11.19	15
16	Dishwashers	54,301	57,788	514,593	8.90	16
17	Maintenance Workers					17
18	Housekeepers	118,712	131,630	1,454,005	11.05	18
19	Laundry	20,665	23,061	244,223	10.59	19
20	Administrator	1,916	2,102	119,667	56.93	20
21	Assistant Administrator					21
22	Other Administrative	14,937	16,981	415,479	24.47	22
23	Office Manager					23
24	Clerical	34,477	39,622	645,059	16.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,802	2,095	73,178	34.93	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,569	6,286	101,156	16.09	31
32	Other Health C: Nrs Sect, WC	7,580	8,584	128,619	14.98	32
33	Other(specify) Barber/Beautcn	4,617	5,244	73,256	13.97	33
34	TOTAL (lines 1 - 33)	943,093	1,062,573	$ 17,094,496 *	$ 16.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	75	$ 2,422	Ln 1, C 3	35
36	Medical Director				36
37	Medical Records Consultant	74	2,210	Ln 10, C 3	37
38	Nurse Consultant	88	4,375	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6,406	226,215	Ln 10a,C 8	40
41	Occupational Therapy Consultant	6,684	188,832	Ln 10a,C 8	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,905	64,061	Ln 10a,C 8	43
44	Activity Consultant	12	662	Ln 11, C 3	44
45	Social Service Consultant	41	2,044	Ln 12, C 3	45
46	Other(specify)				46
47	Medicare Consultant	128	4,599	Ln 21, C 3	47
48					48
49	TOTAL (lines 35 - 48)	15,413	$ 495,420		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,070	$ 254,563	Ln 10, C 3	50
51	Licensed Practical Nurses	263	12,703	Ln 10, C 3	51
52	Nurse Aides	1,136	46,033	Ln 10, C 3	52
53	TOTAL (lines 50 - 52)	6,469	$ 313,299		53

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Beth Welch	Administrator	None	$ 119,667
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 119,667

B. Administrative - Other

Description	Amount
Other Contractual Costs (From County) for Security, Personnel, Purchasing & County Board [Detail on Schedule VIII]	$ 576,373
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 576,373

C. Professional Services

Vendor/Payee	Type	Amount
County Finance & Auditor	Finance & Auditor	$ 66,100
County Audit	Financial Audit	9,941
County Acctg & Budget	Accounting	20,558
Other Misc	Cost Reprt & Acctg Srvcs	18,026
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 114,625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,594
Unemployment Compensation Insurance	33,097
FICA Taxes	1,243,807
Employee Health Insurance	2,280,214
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,385,612
Workers Comp Claims	93,044
Accrued Comp - Retention Expense	2,129
TOTAL (agree to Schedule V, line 22, col.8)	$ 5,056,497

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	0
Health Care Worker Background Check (Indicate # of checks performed)	0
County Nrsg Home Assoc.	3,550
DuPage County Health Dept	1,810
Illinois Dept of Prof Regulation	760
Amer Society of Cnsltnt Pharmacists	630
American Dietetic Association	562
Various other sm amts-per sch	3,861
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,173

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	3,832
Seminar Expense	34,842
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 38,674

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2003 Ending: Nov. 30, 2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **County Nrsg Home Assn of ILL. $3550**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **138,726** Line **10, Col 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **278,892**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **727,028**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Wolf & Company, CPA's** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Final Audit not yet available.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.